**Texas Department of Insurance**
*Division of Workers' Compensation*
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

RENAISSANCE-TERRELL
PO BOX 11527
HOUSTON TX 77293

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

**Respondent Name**
TX ASSOC OF COUNTIES RMP

**Carrier's Austin Representative Box**
Box Number 01

**MFDR Tracking Number**
M4-08-6401-01

**MFDR Date Received**
JUNE 27, 2008

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "It is the position of Renaissance Hospital that the respondent has not reimbursed these services at a fair and reasonable rate as required in TDI-DWC rule 134.401… Our company has purchased national hospital payment data for 'Cleverly and Associates'; a nationally recognized company. This data is known as Med Par Data… Our analysis and application of this data was similar to that done in the 2003 Ingenix Final Report…. The PAF we have established is 250% of our hospital specific Medical Outpatient Prospective Payment System reimbursement rate; this rate is consistent with most commercial and private payers with in this region…"

**Amount in Dispute:** $172.25

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Carrier contends that the reimbursement previously provided is fair and reasonable and no additional reimbursement is due. The Carrier properly documented the reduction in reimbursement for those services where the Division has not set a Maximum Allowable Reimbursement. The Provider has failed to show that it is entitled to additional reimbursement. Additionally, the Division's recent release of the proposed 2008 Hospital Fee Guideline, which now included reimbursement for out-patient procedures based on CMS Outpatient Prospective Payment System, recommends a conversion factor of 130-200%... Because the Provider has been reimbursed consistent with the above parameters, it has been appropriately reimbursed for the procedure…The Carrier contends that Rennaissance [sic] Hospital has failed to show that it is entitled to additional reimbursement over and above the fair and reasonable amount already paid by the Carrier."

**Response Submitted by:** Parker & Associates, LLC, 7600 Chevy Chase Dr., Ste. 350, Austin, TX 78752

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| February 25, 2008 | Outpatient Hospital Services | $172.25 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – Payment is included in the allowance for another service/procedure.
   - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - 5077 – Carriers fair and reasonable for outpatient services is 162% of CMS outpatient prospective payment system (OPPS) based on ambulatory payment classification (APC).
   - 5099 – This service is packaged into the APC rate and not reimbursed separately.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - 1 – Processed as Primary.

**Findings**

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "This data is known as Med Par Data based on this data, we have established a PAF or payment adjustment factor to be applied to our hospital specific Medicare OPPS reimbursement rate and determined this to be our interpretation and application of fair and reasonable."
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

**Authorized Signature**

| | | |
|---|---|---|
| | | October 26, 2012 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.